



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS HAYES DC
PO BOX 198
BARKER TX 77413-0198

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0136-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Regarding the denial, a Functional Capacity Evaluation does not require pre-authorization as defined by Rule 134.600 because a FCE is an evaluation, not treatment. ...Medical records indicate that [injured employee] did not have any FCEs performed prior to the July 28, 2011 FCE ..."

Amount in Dispute: \$576.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor has filed a Request for Dispute Resolution identifying this as a fee dispute. There is, however, a pending and unresolved compensability dispute concerning the extent of the injury. A copy of the Carrier's PLN-1 form dated January 26, 2011 is attached. Accordingly, this request must be held in abeyance in accordance with 28 TAC§ §133.305(b)..."

Response Submitted by: Zurich c/o Flahive, Ogden, and Latson; PO Box 201320; Austin TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2011	97750-FC	\$576.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 relates to MDR – General.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a Benefit Review Conference.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 10 and 26, 2011

- 197 – Precertification/authorization/notification absent.
- 240 – Preauthorization not obtained.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on September 15, 2011. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Texas Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals." The appropriate dispute process for unresolved issues of compensability, extent and/or liability for the claim requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute and, as a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 22, 2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.